

HAND SURGERY

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ASSOCIATION NEWS

AAHS in Kuwait

Nash Naam, MD

In continuation of the American Association for Hand Surgery's efforts to spread hand surgery education beyond the shores of the Americas, our association, in cooperation with the Kuwaiti Society for Surgery of the Hand (KSSH), participated in an international hand surgery conference in Kuwait City, Kuwait from January 22 through 24, 2009. The conference was the culmination of the association's effort to take its international hand surgery education message to the Middle East and after the successful Cairo International meeting in 2008. As a result of the success

of the Cairo meeting the Kuwaitis asked the AAHS to cooperate on a comprehensive hand surgery conference in Kuwait. Nash Naam, MD representing AAHS and Ahmed El Morshidy, MD representing KSSH shared in organizing the meeting.

The meeting took place in the Islamic Center in Kuwait City. It was chaired by Dr. Husam Basheer. The AAHS faculty included three Past Presidents: Scott Kozin, MD; Richard Berger, MD and Bob Russell, MD joined by Brian Adams, MD; Mark

Baratz, MD; and Nash Naam, MD. Dr. Gunter German from Germany was also one of the faculty members

The meeting lasted 3 days and it covered a wide spectrum of topics in hand surgery ranging from congenital differences, hand trauma, complex hand reconstruction to wrist biomechanics,

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Conference faculty members (left to right): Drs. Nash Naam, Brian Adams, Mark Baratz, Scott Kozin and Richard Berger.



Faculty and host committee at the entrance of the conference hall

ASSOCIATION NEWS

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replanations and total joint arthroplasty.

About 150 participants from Kuwait and the surrounding Middle Eastern countries attended the meeting. The majority of the attendees were orthopedic and plastic surgeons with some therapists and nurses. It was notable that one female physician was in attendance. She is the only female plastic surgeon in Kuwait

All the faculty members were accompanied by their spouses and that allowed for more social interactions with the Kuwaitis. Actually the spouses were treated to attending a fancy wedding reception which was limited to women only.



Scott Kozin, MD lecturing

The Faculty is very grateful for the hospitality of the Kuwaiti people and the organizing committee. It has been a wonderful learning experience for all of us to see and interact with people from that part of the world.

The meeting was very successful based on the interaction with the participants and the feedback from the organizers and the attendees. Now, as a result of this success there are communications between Dr. Basheer, and Dr. Kozin to hold a pediatric hand surgery conference in Kuwait in 2010.

We hope to continue our association's dream to spread hand surgery education to the far corners of our world. **H**



Faculty and host committee



Faculty with Drs. Morshidy and Basheer

International Federation of Societies for Surgery of the Hand Calendar

There is nothing quite like the camaraderie of fellow surgeons in the specialty comparing notes on the latest techniques being employed around the globe. To help you to stay in touch with the global community of hand surgeons, the IFSSH will be hosting several meetings in the near future.

8th Congress of Asia Pacific Federation of Societies for Surgery of the Hand (APFSSH)
November 13–15, 2009
Kaoshiung, Taiwan

IFSHT Congress
June 24–26, 2010
Orlando, FL (NOT Korea)
www.hands2010.com

XIth IFSSH Congress
October 31–November 4, 2010
Seoul, Korea
www.ifssh2010.com

XIIth IFSSH–IXth IFSHT Congress
March, 2013
New Delhi, India

IFSSH Web site: The IFSSH Web site is continually updated and is the main means of communication between member societies. The Executive welcomes information from all member societies, including notice of national meetings and matters of interest, both current and historical, for distribution to our members. The website address is www.ifssh.org. **H**

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In Appreciation

This edition marks a change in the *Hand Surgery Quarterly* with the passing of the pen from Dr. Peter Amadio. We give our humble thanks and praise to Dr. Amadio for his decade long effort as the editor of the newsletter. Peter is currently a Professor of Orthopaedic Surgery and Biomedical Engineering at the Mayo Clinic in Rochester Minnesota. He served as the 27th President of the AAHS in 1998-1999. Peter took on the newsletter as its second editor, the year after he served as President of the organization. The first and only other editor of the *Hand Surgery Quarterly* was Dr. James Hoehn, who also served as the President of

the AAHS in 1983-1984. Peter has been successful in shaping the form of the newsletter and guided its transition to an on-line format in 2007.

The editorial columns written by Dr. Amadio back to 2002 can be found on the association's Web site and make interesting reading. A review of these columns is a fascinating window into the thinking of Dr. Amadio, something I won't elaborate on, and an amazing otherwise unavailable mirror into the recent history of hand surgery reflected from an involved expert surgeon, teacher, researcher, and a member of society. In the Autumn 2002 edition he discussed the study of the way knowledge is built up, epistemology, from the perspective of Kienbock's disease. He reviewed the two fundamental rules of life. (You will have to look it up!) In

Spring 2005 he wrote fondly about Dr. Miguel Vargas-Busquet, a wonderful surgeon who lives on through our Vargas award. His last column in Winter 2009 discussed an important interest of the hand Association, outreach to developing countries. It is rare for a hand surgeon to have such a profound written record of his thoughts and opinions beyond the more formal medical journals. I encourage you to read these and discuss them with Peter.

Dr. Amadio nurtured the newsletter through an interesting period of time in hand surgery. We have been made wiser by his thoughts.

Thank you, Dr. Amadio.

FROM THE EDITOR'S DESK

HAND SURGERY QUARTERLY

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Nicholas Vedder, MD

Editor

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Hand Surgery Quarterly is a publication of The American Association for Hand Surgery and is published strictly for the members of AAHS. This publication is designed as a forum for open discussion and debate among the AAHS membership. Opinions discussed are those of the authors or speakers and are not necessarily the position, posture or stance of the Association.

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This edition of the *Hand Surgery Quarterly* finds us once again in the throes of a national discussion about health care reform. President Obama has linked health care to the economic wellbeing of the nation, and currently in a once in a lifetime economic crisis, the nation is listening. Our "Around the Hand Table" discussion in this edition focuses on a timely topic that may be impacted by reform. I encourage you to read it.

This is an exciting time to be a hand surgeon. We have a core group of surgeons with advanced skills in education. The use of the internet continues to evolve. There is a vigorous resurgence of interest in joint implants with new designs and materials. Nerve transfers are a real clinical entity requiring us to re-invent anatomy class. We have wonderful new plates for distal radius fracture care. The outcomes movement is maturing, resulting in good tools to measure the results of

our care. Evidence Based Medicine is an accepted goal. The American Association for Hand Surgery has its annual meeting in a warm location in January! I encourage us to put them all together.

If you have ideas for the *Hand Surgery Quarterly* I would like to hear from you. What type of content do you think would be interesting in this type of format? We have the luxury of informality and the relevance of immediacy to make the newsletter informative and useful. If you would like to participate in, or organize a round table discussion please let me know. The membership would like to hear your opinions.

H



STEVEN MCCABE, MD

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In Progress

It continues to be an honor for me to serve as the AAHS President this year. I am working with your Board of Directors, committee chairs, and committee members to promote the value and benefits of membership, expanding our membership, engaging members in the activities of the organization, and planning for what will be an outstanding meeting next January 6-9 at the beautiful Boca Raton Resort in Florida.


Previously I had noted that the central theme of my presidency is unity: promoting unity within the broad field of hand surgery, involving hand surgeons and hand therapists from the AAHS and all hand organizations to capitalize on our individual strengths and shared commitments and to work together for the future of hand surgery. I believe that we are making good progress on that front.

We have had several meetings between the presidential lines of the AAHS and ASSH already and are pursuing several joint ventures that we feel will make the broader field of hand surgery stronger. The level of cooperation and collaboration between the two hand organizations has never been stronger, ranging from a joint Maintenance of Certification task force, possible journal collaboration, a joint hand caucus within the AMA, a strong and coherent voice within the American Academy of Orthopedic Surgeons' Board of Specialty Societies, joint sponsorship of numerous activities, and promoting each other's meetings and programs. This cooperation exists not only among the surgeon leadership, but also between our two extremely effective executive directors. I believe that all of these efforts hold promise to advance clinical care, education, and research in the field of hand surgery.

Our collaboration with the American Society of Plastic Surgeons is also stronger than ever. Several of our members sit on the ASPS Board and can thus effectively advocate for the clinical, educational, and research priorities of hand surgery. With the AAHS management services now provided by ASPS we have been able to take advantage of their tremendous organizational resources, a change that has greatly improved our central operations. Through a cooperative program with the Plastic Surgery Educational Foundation, our members are now eligible for expanded research grant opportunities. The Executive Director of ASPS, Mr. Paul Pomerantz has agreed to organize and facilitate a strategic planning session for our Board meeting this summer. You will all soon receive an invitation to participate in a member needs survey, through which we hope that

you will all share your candid thoughts on how we can make the AAHS a more valuable and important organization to you.

Our collaboration and coordination with the ASRM and ASPN continues as we plan both for the 2010 meeting and into the future. Our program chairs, Kevin Chung and Gretchen Kaiser-Bodell, in collaboration with the program committee, have developed an outstanding program for the January meeting. I know that you will enjoy both the scientific and social programs that we are planning.

I am very excited about these developments and will continue to share our progress throughout the upcoming year, as we continue to prepare for a great meeting in Boca Raton Florida next January 6-9, 2010. I hope to see all of you there! 



NICHOLAS VEDDER,
MD

AAHS Calendar 2009

July 10-12, 2009

Stephen Mathes Reconstructive Symposium
Sponsored by ASPS, AAHS, ASRM, ASPN, ASMS
Dallas, Texas

July 24 - 25, 2009

AAHS Mid-Year Board of Directors Meeting
Lake Tahoe, CA

September 3-5, 2009

Annual Meeting - Combined of the ASHT & ASSH
San Francisco, CA

October 23-27, 2009

ASPS Annual Meeting
Seattle, WA

2010

January 6-9, 2010

AAHS 40th Annual Meeting
Boca Raton Resort and Club
Boca Raton, FL

March 10-13, 2010

AAOS Annual Meeting
New Orleans, LA

October 1-6, 2010

ASPS Annual Meeting
Toronto, ON, Canada

October 7-9, 2010

ASSH Annual Meeting
Boston, MA

2011

January 12-15, 2011

AAHS 41st Annual Meeting
Ritz Carlton Cancun
Cancun, MX

February 16-20, 2011

AAOS Annual Meeting
San Diego, CA

September 8-10, 2011

ASSH Annual Meeting
Las Vegas, NV

September 23-28, 2011

ASPS Annual Meeting
Denver, CO

For information contact: AAHS
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AAHS 2009 COMPREHENSIVE HAND SURGERY REVIEW COURSE

Tendonopathies and Dupuytren's Contracture

Jennifer M. Wolf, MD

Compressive Neuropathies & CRPS

Robert Spinner, MD

Thumb Basal Joint Arthritis and Inflammatory Arthritis

Marco Rizzo, MD

Distal Radius Fractures

David Dennison, MD

Distal Radioulnar Joint

Brian Adams, MD

Scaphoid Fractures and Non-Unions, Kienbocks Disease

Alexander Y. Shin, MD

Carpal Instability, Wrist Arthritis

Steven L. Moran, MD

Fractures of the Metacarpals and Phalanges

Brian Carlsen, MD

Flexor & Extensor Tendon Injuries

Jeffery Friedrich, MD

Infections of the Hand

Kevin D. Plancher, MD, MS, FACS, FAAOS

Congenital Hand Differences

Steven L. Moran, MD

Tumors of the Hand and Wrist

Carol Morris, MD

Soft Tissue Coverage in the Hands

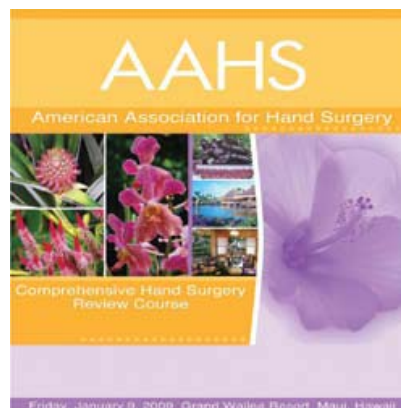
William C. Pederson, MD

Tendon Transfers for the Hand

Doug Sammer, MD

Vascular Disorders of the Hand/Replantation

Peter M. Murray, MD



A must-have resource.

Purchase this special limited edition DVD and put the entire 2009 Comprehensive Hand Surgery Review Course at your fingertips. This invaluable resource includes faculty presentations of 15 topics covered on board examinations, the hand surgery certification examination and resident in-training examinations. Recorded during the AAHS 2009 Annual Meeting, it's a resource you'll turn to over and over again.

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The Crisis in Hand Trauma Coverage

Our moderator for this panel is L. Scott Levin, MD, FACS, Duke University Medical Center, Durham, NC. He is joined by noted reconstructive microsurgions Neil F. Jones, MD, Professor and Chief of Hand Surgery, University of California Irvine, Orange, CA, and Chris Pederson, MD, FACS, of The Hand Center of San Antonio, San Antonio, TX. Providing perspective from the hand therapist viewpoint is Cia G. Passig, OTR/L CHT, Milliken Hand Rehabilitation Center, St. Louis, MO.

Dr. Levin: First off, I'd like to share with you some progress I've made. I just came back from the Hand Council and one of the issues about the whole problem of hand trauma crisis revolves around the regionalization of care in the Level 1, Level 2, and Level 3 centers. According to the guidelines of what they call the Green Book, the American College of Surgeons (ACS) has stipulated that a Level 1 center for trauma must have "micro vascular" capabilities. But what that means is if somebody can do a free tram reconstruction from 8 am to 1 in the afternoon the Level 1 center "qualifies" as a micro vascular center. Yet at 2 in the afternoon, if you called up and a 4 year old child's hand was cut off, there would be nobody there to do the replant.

So what I've done in directing the Hand Trauma Taskforce for ASSH and AAHS is written the presidents of the ASPS, the American College of Surgeons, and the Academy of Orthopedic Surgeons to support a letter directed to the American College of Surgeons Committee on Trauma that will basically change the Green Book. We have requested the Green Book be changed to say specifically that in order to be a Level 1 center you must have 24/7 micro vascular capability for major limb replantation, digital replantation, and revascularization procedures of the upper extremity. And the only way you can qualify is to have that capability, or, through contract, to arrange a transfer agreement with another Level 1 center that does have it.

Now, if this goes through, then

it's going to force the Level 1 centers who have opted out of hand trauma care, or particularly complex micro vascular care to comply with the guidelines. If they're not willing to change the Green Book, then the rhetorical point is, why should we do replants at our center anymore? Why should anybody do it? Obviously people are doing it because its part of training and there's an ethical obligation of the people who remain behind doing it. But obviously there are less and less people. So that's the first order of business that the Hand Trauma Taskforce has accomplished, that is to organize a pathway to change the American College of Surgeons Guidelines.

So let's take that first point and go around the room. Neil, what are your thoughts about that?

Dr. Jones: Well I'm interested in this definition for a Level 1 trauma center because the original guidelines required a hand surgeon, a neurosurgeon, and obviously a general surgeon, and, I think, a cardiac surgeon. Those four were mandatory. So you're suggesting changing it from a hand surgeon to a micro surgeon?

Dr. Levin: No. Actually the Green Book as it's written says now that a Level 1 trauma center has to have micro vascular capability. That's already defined in the book. The problem is by just saying micro vascular capability, as I said, means you can be doing a peripheral nerve repair at 10 in the morning, call yourself a micro surgeon, and then not take emergency call for microsurgical cases. Then the adminis-

trators say "Oh we have Jones, he does microsurgery." But yet Jones is not available. He could say "I do peripheral nerve surgery under the scope, or fix radial artery occlusion, but I'm not taking replant calls."

Dr. Jones: Well I can give you the perfect example of this situation. For the counties of Los Angeles and Orange County, which is a total of maybe 20 million people, there are five Level 1 trauma centers but only three of those are able to do major complex limb trauma and replantation, and two of them definitely cannot do replantation.

Dr. Levin: Right, but that has to be documented in our dialogue here because this is exactly the problem. So you're asking basically one center to service 20 million people.

Dr. Jones: I think that would be impossible, because you would need to have an enormous number of hand surgeons and residents and fellows to accomplish that. It will have to be organized at some higher level like the state level or even the federal level.



WHY WE HAVE THE CRISIS ARE LACK OF TRAINING, THE LIFESTYLE OF GENERATION X WHICH IS JUST A SOCIAL FACT, THE REIMBURSEMENT, AND THE FACT THAT ITS HARD WORK.

L. SCOTT LEVIN, MD

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Dr. Levin: Yes, that's what we're working towards with the American College of Surgeons. We are trying to partner with Tom Russell, the Executive Director. He's been at the Council where I've presented this. To take a giant step back, it's not just us micro vascular hand replant doctors that are facing this problem. The Institute of Medicine's Report from 2006 identifies a huge problem with trauma care in the United States. Underfunded patients, surgeons and specialists not available for pediatric care, other multiple surgical specialties, such as neurosurgery are other examples of that crisis. The College is driving through legislation that will insist on paying surgeons for trauma care, helping with TORT reforms so liabilities issues aren't a deterrent, and making sure that hospitals have appropriate support staff available. The point of all this is that we as surgeons who are in the trenches, are the people who are continuing to deal with this.

Now Chris I know you've mentioned the things you do at the Hand Center that were actually very good strategies, or at least ways that you cope. Can you share those with us?

Dr. Pederson: Several years ago we were getting everything from the Rio Grande Valley, which is a 6 hour drive, sent to us. It was relatively minor problems, such as infections and other problems. A number of years ago, we had sent out some posters to all the hospitals in South Texas to call us for potential replants, but we ended up getting everything else. Well, there was an organization I wasn't aware of called the South Texas Regional Advisory Council for Trauma, or STRAC, and they organize trauma care in this area of South Texas, which is called Trauma Service Area P. It includes some 20-odd counties, is 26,000 square miles, and there's actually two Level 1 trauma

centers in this area, but they're both in San Antonio. Now this is obviously different than where Neil is, as it's much larger than the area that he services but there's not nearly as many people, only about 2.5 million.

However, we worked with STRAC and came up with criteria for transfer for revascularization or replant, and we looked very carefully at the EMTALA laws and such things. Since we don't take call in Dimmit County, we are not necessarily obligated to take care of non-emergent cases from there, but they can obviously say that the patient needs to be transferred for a higher level of care. We believed if there was an orthopedic surgeon there they could take care of many of those patients. This set of criteria has cut down our unwarranted transfers about 35% between the year before we implemented it and the year after we implemented it. In this area we are the only people that do replants, and we are in private practice. The University doesn't do replants. The military does them sometimes if the right guy's on call for Brooke Army Medical Center.

Dr. Levin: But it's variable.

Dr. Pederson: It's extremely variable. And just as an example, Tuesday night a kid flew from Amarillo (which is about 500 miles) down here with an amputated thumb that I replanted. And that's not even in our real catchment area and certainly out of our normal trauma coverage area. But what I presented at Maui at the AAHS meeting in January was that we in fact cover an area that's roughly 90,000 square miles. And again, the population is not that of Greater L.A. by any means, but we get them sent from all over the place.

But working with the STRAC, it has become better. What used to happen is the general surgeon would just accept the patient as trauma, and it would be transferred whether it was appropriate or not. Now the general surgeons will not accept hand trauma without calling us, and we speak with the local

referring physician first. If it's something like an open fracture of the metacarpal that can be managed locally then we won't accept it. If it's not emergent and the local community simply lacks the expertise, we have them send the patient to the office next day. But replantation remains somewhat of an issue, and we get patients transferred from extremely far away at times. But it has helped working with the local governmental medical trauma service area.

Dr. Levin: Let me ask you a question though. As far as I know, all the ER doctor has to tell me is, one, we don't have a hand surgeon or, two, the hand surgeon said he or she does not feel comfortable. I've gone so far as to say, Has the hand surgeon come in and seen the patient? No? Then I say I'm not accepting the transfer until they personally evaluate the patient and call me and explain why they can't handle it.

Dr. Pederson: That's what our rule is. Our rule is that the highest level of care needs to evaluate the patient. If that's the general orthopedic surgeon, fine, or maybe the local hand surgeon or plastic surgeon needs to see the patient and we need to discuss it with that person. We will not accept the transfer unless we've discussed it with that person, just as you've said you do.

Dr. Levin: Yes, but the problem that we see in our area is when the transferring doctor says, "I think it's a neurovascular injury and I'm just not doing that anymore" or "I don't feel comfortable." That's all recorded through our transfer center. So if I respond that I'm not accepting the



I THINK REPLANTATION IS DIFFERENT AND I THINK THERE SHOULD BE CENTERS SET UP THAT ARE RECOGNIZED FOR EXPERIENCE, PRIMARILY, AND OBVIOUSLY EXCELLENCE.

WILLIAM (CHRIS) PEDERSON, MD

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patient because you're not comfortable, I am in violation of EMTALA. Our surveys and data suggests that there's a lot of capable surgeons out there that are bypassed. The point I'm making is that when the rhetoric is used "we don't feel comfortable" or "our microscope is broken," or "I just finished a replant, I know I'm getting paid for it but I'm too tired," it becomes your problem under EMTALA. Neil, am I right?

Dr. Jones: You're absolutely right, and we are totally in agreement. Basically there are just a few of us left, as you say, "in the trenches" who are propping up the system. It's an abdication of responsibility at multiple levels. It's a lack of responsibility at the federal government level because they have millions of uninsured patients. It's at the state level because they haven't developed centers of excellence to deal with this problem. And it's a failure of responsibility of individual hospitals and also individual surgeons. In a way it's exacerbated by the EMTALA rules because hospitals and physicians use phrases like 'I'm not comfortable' or 'I don't think I can repair this artery and it needs a higher level of care'. If somebody calls me, like you and Chris, I demand that I talk to the plastic surgeon or the orthopedic surgeon or the hand surgeon and have them explain why it requires a higher level of care. And many times these cases don't require a higher level of care.

Dr. Levin: Of course not.

Dr. Jones: Problems such as an abscess of the hand, infections, gunshot wounds, knife wounds... obviously some of them are amputations, but we've had things like tip amputations transferred. It seems to be prevalent after 6 o'clock at night, or on a weekend...

Dr. Levin: The uninsured patient is particularly susceptible to this type of transfer.

Dr. Jones: And the patient's uninsured. And they're being transferred to us, the last people in the trenches, and in the university hospitals, because we are the only ones that still have that ethical responsibility to take care of the patients. But everybody else, from the level of the federal government, to the state government, to the hospital, to the individual surgeon, has basically given up their responsibility. And that's the crisis.

Dr. Pederson: I think hand trauma and replantation are two different issues entirely, however, because there are not a lot of really competent replant surgeons, frankly. I'm sorry, there are just not.

Dr. Levin: Of course there aren't.

Dr. Jones: I agree with you also.

Dr. Pederson: And I think that a replant center is different than a hand trauma center. Just tonight we got a call from five hours away about an open DIP joint injury that no one locally is "comfortable taking care of." Okay, the patient is likely uninsured and I'm sure he'll be here at 3 am, but I think replantation is different. There should be centers set up that are recognized for experience, primarily, and obviously excellence. But again, I think a replant is different than an open DIP joint. I am quite happy to take a replantable digit or hand or part under any circumstance. The problem is that when you do that, and even though we're not at the university, you get the reputation for taking everything. And so I agree with Neil completely.

I agree with you Scott as well: if they say it needs to go to a higher level of care, it is an EMTALA violation not to accept the patient. However, if the patient requires a low level of care, as Neil said, and the injury is something that any orthopaedic or plastic surgeon can take care of, it truly is a waste of resources to transfer that patient.

Dr. Levin: Let's go onto the next discussion point. We asked the questions, "Are you capable of replants, are you willing to do them if you're paid, and so on?" Fifty percent of

the people we surveyed answered the questionnaire, which is pretty high. Second, we identified approximately 454 surgeons who said that they would be willing to take replant call. Are you capable of replant call? Four hundred and fifty four, which was about 40%, said they're capable. The next question was, "Are you willing to do it?" and about the same percentage said, "Yes." That number surprised me. We should

move to have the College create 10 to 15 centers around the country. There is manpower—in theory—out there, and we'll try to regionalize. The other thing that the survey brought out is that our hand surgery community feels it would be worthwhile to have an educational partnership with the American Colleges of Emergency Physicians. If we start to educate the ER docs in Level 3 centers, how to drain a felon, and how to evaluate hands better, in theory it'll stop the flow

of a lot of patients with minor problems like the nail bed injuries. We had a 12 year old hispanic child two years ago with a fingertip injury and the ER doctor called another Level 1 trauma center in our state. The attending surgeon would not even talk to the ER attending from that referral hospital. This went back and forth. It was horrible. We eventually accepted the child in transfer and did a composite graft in the ER at 2 o'clock in the morning. There's no reason for that to occur. And that was an EMTALA violation that was called on the institution that did not accept the child. These examples of egregious physician behavior and institution-



THE CONCEPT WAS THAT YOU HAD TO TRAIN A CADRE OF SURGEONS WHO COULD DEAL WITH HAND INJURIES RIGHT AT THE BEGINNING AND HOPEFULLY LESSEN THE NUMBER OF COMPLICATIONS.

NEIL F. JONES, MD

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al neglect, are repeated all over the country.

Neil and Chris, do you think that doing a better job in the education of ER physicians is going to make any difference?

Dr. Pederson: No, I don't think so—I don't know! I think we're educating our Fellows as well as we can. The problem is our Fellows get a very good micro experience, as your Fellows do I'm sure, but they choose to go out and not do microvascular because they may be all by themselves, and they don't have anybody to help them. You can do a replant without help, but it's nice to have somebody around if it's several fingers or a big case. And I honestly agree with Neil saying it's an abrogation of duty.

However, a lot of our trainees don't have the setup to routinely perform replantation and complex extremity trauma. But I don't know how to fix that, quite honestly.

Dr. Levin: Regionalization.

Dr. Pederson: I think regionalization is a good answer, but...

Dr. Jones: To answer your question Scott, I think that's probably a retrograde step. The case of the 12-year-old you talked about is again a clear example of the abdication of responsibility by the plastic surgeon or orthopedic surgeon or hand surgeon in that referring community. And it's wrong for them to then say it's an EMTALA violation by the Level 1 trauma center. It's the responsibility of the surgeon in that community, or that hospital, because the patient did not need to be referred to a higher level of care.

Dr. Levin: You're absolutely right.

Dr. Jones: I know there are many emergency room physicians who are quite technically proficient, but I think if you educate the emergency room physicians to do some simple procedures in the ER, then you'll probably have to take care of the problems. The whole essence of

why the Hand Society (ASSH) and the Hand Association (AAHS) started came from the hand surgery centers after World War II. The concept was that you had to train a cadre of surgeons who could deal with hand injuries right at the beginning and hopefully lessen the number of complications that were resulting from the general surgeons or emergency room physicians who were dealing with those hand injuries at that time. So in a way we'd be setting the clock back 50 to 70 years.

Dr. Levin: I think that's a good point Neil. This response of the education of the ER doctors actually came from the members that answered the survey: to train the ER doctors more specifically on the type of injuries that need to be referred. So what it does support is the directive to stratify care, just as Chris has done in Texas. I think that's a good place to start. There's no way that a community should be sending out a nail bed injury. It's that simple.

Dr. Pederson: Absolutely.

Ms. Passig: I was talking to one of our surgeons this week about this topic to prepare for our discussion and he agreed that trauma call was a big issue. He stated that many hospitals in the area have hand surgeons on call but still send the patients to our hospital stating that they need microsurgery or that it isn't something they are comfortable doing. Many times they haven't even seen the patient, and primarily they are uninsured.

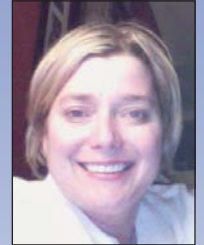
Dr. Jones: The first factor leading to the crisis is reimbursement—and the second and probably the third. The fourth factor is actually a change in the attitude of surgeons. Maybe we grew up in an era where we had a responsibility for patients 24 hours a day, 7 days a week. Nowadays many surgeons do not want to work beyond 6 o'clock at night. And we just have to face that. Many surgeons do not want to be on call and therefore they will use these excuses to get out of being called. They're on call on a schedule on somebody's computer screen when the telephone operator calls

them up, but when they're called, they will give the telephone operator an excuse that they can't come in or it's beyond their level of expertise. And that's another major factor in this crisis. And the fifth factor, I think, is I'm not so sure that we're really training hand Fellows and orthopedic Residents and plastic Residents to the level that's required. I think the RRC, and maybe the various societies have dumbed down the training requirements.

I give you this example: when my Hand Fellowship was being reviewed maybe 2 years ago, the person reviewing it stated his opinion that doing replants should not be a criteria for a Hand Fellowship. If we're hearing this from an RRC reviewer, then, over time, we're not going to train many surgeons who are able to do replants or deal with complex limb injuries. And that has repercussions if we were to have a major disaster in this country.

If we were to have a major terrorist attack, there are very few surgeons that can take care of major mutilating limb injuries. So it is a crisis of reimbursement, lifestyle, and training and somehow you have to address all three. Maybe someone in the higher echelons of the RRC or the various Boards, has to say that we must redefine our criteria of what a 1-year training in hand surgery entails, and maybe to be eligible to take your Boards you have to do a certain number of replants.

Dr. Levin: Neil, I cannot agree with you more. The third point about this training is the fact that people are calling their hand programs a Hand and Micro Vascular Training



OUR ISSUES IN OUR CLINIC HAVE MORE TO DO WITH BEING ABLE TO SEE THE PATIENT ADEQUATELY AND HAVING EXPERIENCED PERSONNEL TO TRANSFER THEIR CARE IN OUTLYING AREAS.

CIA PASSIG, OTRL, CHT

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Program, which is not accurate. I would define micro vascular capability as replantation, and a cadre of flaps. I can tell you that there are many hand programs where people have come out and can't even do a conventional groin flap. And the only thing that's emphasized is carpal tunnel release and trigger finger and putting a plate on a distal radius. All well and good, all part of hand surgery, all vitally important. Bob Szabo, the president-elect [of ASSH] has even proposed a two year hand Fellowship, funding aside, RRC aside, because the curriculum may have to include a concentrated program of six months of micro vascular surgery. He has thought about this creatively, about mixed models, sharing Fellows, different curriculum, and that the third point, concerning a lack of true education in these areas, is really a very major point. And we keep saying, yeah, it's lifestyle, yeah, it's reimbursement:

those are very important, granted. But if we were paying \$20,000 a replant and \$5,000 a night to take call, a lot of people these days would be lining up. Bill Zamboni in Las Vegas pays his neurosurgeons \$4,000 a night to take call. Okay, that's not a bad piece of change. We don't do that, but this third piece, of education, is really important.

Both of you do brachial plexus surgery. How many hand and micro Fellowships teach people how to do brachial plexus surgery?

Dr. Jones: Probably less than 10 around the country.

Dr. Levin: My point is that we wouldn't have the crisis if we did pay well but we also trained well, and the lifestyle was not onerous, meaning, within a regional center of excellence you could do 24 on, 24 off. Who *wants* to have that lifestyle? Well, there may be some people that want to be hand trauma hospitalists. That's a concept and that's all they do. That model works in Europe for traumatology.

I think the four factors clearly, in summary, of why we have the crisis

are: lack of training, the lifestyle of Generation X which is just a social fact, the reimbursement, and the fact that it's hard work. And it's inopportune, and we've noted a lot of the patients are uninsured, but there are good models around. Jim Chang told me at Stanford they get paid per RVU, whether the patients are insured or not.

Dr. Jones: There's another avenue that can help in the resolution, and that is in the AMA CPT and RUC committees. Dan Nagle and I went to them several times and I think

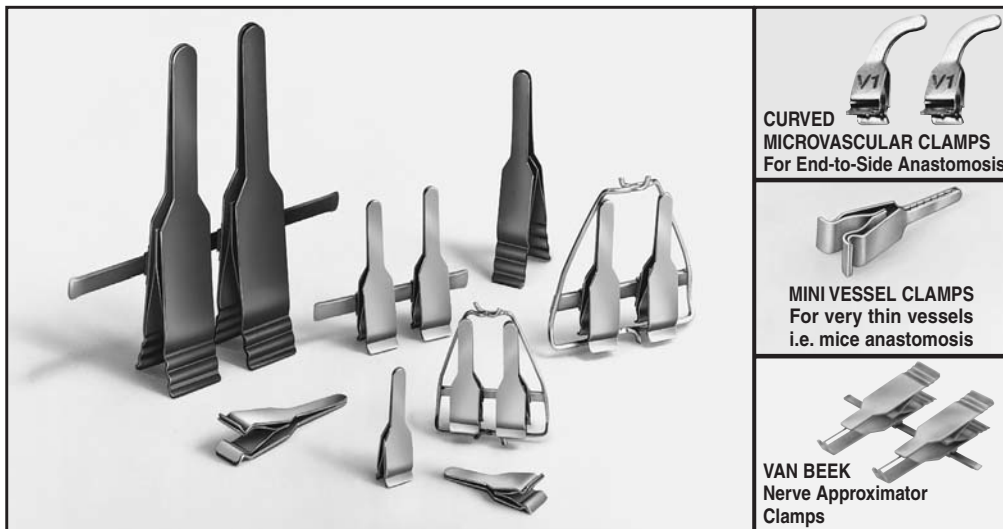
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we got the highest reimbursement for some of the replant codes.

Dr. Levin: It's like a heart transplant.

Dr. Jones: People really do not understand the complexity of a replant and how long it takes. And I think somehow there ought to be a concerted effort to try and renegotiate some of those codes, and especially for replanting multiple fingers. If you replant one finger and it's reimbursed badly, the second finger which is just as much work,

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another 6 hours of work, is 50% of the initial reimbursement. If that was changed, there might be more people willing to do it.

Dr. Levin: Chris, do you have any other comments?

Dr. Pederson: Well, I think it's interesting to me that the criteria for replant has probably changed even beyond what it was 10 years ago. We just don't see as many as we did 15 or 20 years ago. We see more inappropriate transfers, but we're not seeing quite as many replants come in. I think people are more aware of the criteria. But there are still things that remain good criteria for replantation. I agree with everything you said about how we are dumbing down our training, but I think, quite frankly, the work hours rule is part of the problem. Especially if they lower it to 57 hours. One of the orthopedic residents the other day told me he thought 80 was just about right and 57 would be perfect. This is a real problem in my mind. We're training people that don't expect to have to work all night. I don't like to work all night but I still accept it as part of the job. Unfortunately, a lot of people don't accept it.

Dr. Levin: I think we are making some incremental progress, and the true crossroads is coming. I have talked to the college at length and they have the power at least to change the rule books. The whole other factor is, how are those rules going to be enforced? It's going to be an uphill battle and it's going to be a race between how many men are standing to do this work and how fast the crisis gets addressed by change in legislation and reimbursement. And my fear is that surgeons like the current panelists on this call will either give up or stop doing it and then there's going to be nobody to do it if things don't change.

Dr. Jones: I think that's a very pertinent point: that maybe we all think of ourselves as young, but we're

getting to the last 10 years of our professional career and there are less and less micro hand surgeons coming up through the ranks to fill our shoes. And that's going to make the crisis even *more* of a crisis. Two other things might impact on this crisis. If Obama introduces a universal form of health coverage, then that will take care of a lot of the inappropriate transfers. So that may take away a little bit of the problem. It sounds terrible to say, but if we were to have a major catastrophe with a lot of limb injuries, that would really bring the crisis home to the federal and the state governments and maybe that would then force the crisis to be examined at a very high level and hopefully some solution would follow. Just like at the end of World War II, there were huge numbers of returning military personnel with extremity injuries, and that led to the development of the specialized hand units. Maybe that's the way centers of excellence will be developed: unfortunately, after some sort of major catastrophe.

Dr. Levin: Well I think again, that's another great point Neil. There are a lot of health care research grants now to explore the demographics of trauma and the impact of trauma on society. Maybe the hand surgery associations and the micro society could look into what the grading agencies are and maybe use this hand trauma crisis as part of, as you said, the terrorism funding.

For example, one of the guys in our institution has a \$75 million grant to create a separate institute to study biologic warfare in the case we're attacked. This would be a lot cheaper for the government to put in a regional care program, a training program that would assure adequate numbers of people that could care for these mutilated limbs. And I think that's pertinent and could be the subject of a future discussion. I do think on a personal level that if the American Colleges of Emergency Physicians would have a little more hand intensive training, they may be able to do more and limit their complications, and triage care more effectively. And

that in and of itself may cut down on unnecessary referrals.

Chris do you have any other points you want to make, or Neil?

Dr. Pederson: I just think that what we have said is it's going to take a combination of factors if this is ever going to happen. I think it's going to take government initiative, it's going to take us trying to train people properly to do this. And I think it's going to take a lot of cooperation between surgeons. I think it'll be interesting to see. They want to limit CEO's compensation. It will be interesting to see how much they want to limit ours for doing this work. But I agree with Neil and you that it's going to become a point where nobody's going to want to do it because it's late at night and the presence of these other factors. I just think it's going to take a combination of factors and working through the various Societies and with government, as you said.

Dr. Levin: Neil, final word please?

Dr. Jones: I admire what you're doing Scott and I think it's certainly worthwhile trying to bring it to the attention of the legislators. But I think if it's going to happen, it's going to happen through 3 different avenues. Firstly, Obama may mandate universal health care coverage—that will help. Secondly, if we were to have a real major catastrophe in the United States or a terrorist attack with a huge number of limb injuries, it would demonstrate just how deficient we are, both in training surgeons and in the number of surgeons that can deal effectively with these problems. And finally, I think the crisis will become even more apparent over the next 10 years, because most of the surgeons that are in the trenches now are going to retire, and there's very, very few people being trained to fill the shoes of those people retiring. So I think all these 3 factors are going to bring the crisis more to a head. And then hopefully there will be some solutions mandated at a very high level.

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Dr. Levin: Well I actually was a little bit skeptical about the call when we started, but I think this is a lot of good information we've gotten down. Now I'll call on our hand therapist colleague, Cia. We haven't purposely excluded you, but obviously we're in the trenches and we can't give you the patients if we don't replant them.

Ms. Passig: Yes, this is true. Our issues in our clinic have more to do with being able to see the patient adequately and having experienced personnel to transfer their care in outlying areas. We perform a fair amount of non-reimbursed care but we're limited to 6 visits regardless of what their problem is. So it gets really tricky to give them the care they need and stay in this 6-visit limit.

Dr. Levin: Right, and I'm glad you brought that up. Therapy programs don't have a way to make up lost revenue as readily as we can with other procedures. We see cases where the benefits of complex trauma surgery are not realized because of the inability to secure appropriate therapy following surgery.

Ms. Passig: I think that we struggle ethically with this issue. We are luckier than most clinics that we can go to our superiors and possibly get approval for more visits. That isn't the case in many clinics in the city. Many times, they will see them for the initial splint fabrication to protect their surgery but they won't necessarily see them afterwards. Our hands are tied by no insurance.

Another issue for us is that a lot of these people live hours away and there's no one in their area that has experience treating these injuries.

Dr. Levin: Well, I'd ask you to go back to your OT/PT therapy/hand therapy organizations and your leadership. It might be helpful to get their buy-in to the process because it impacts on you and your professional world as well. And all

not only the surgeons but the therapists in going forward with these regional centers and centers of excellence. Supplemental funding from either government or third party payers for your health systems, I think would help hand therapists as well.

Final comments. Chris you're in a little different situation but you're basically functioning as the highest possible level academic center in your vicinity. The problem we have is that as long as we keep doing it and doing it for nothing, or have the intensity or commitment to do it

because we know it's the right thing and we're proud of what we can do, we will do it. And so systems are enabling us. If I went to Duke and said, You know, we're not doing this anymore, you know what they would say? Fine. I don't think our health systems, when push comes to shove, really care whether we do this or not. Let's just assume they lose money. So that's also a disconnect.

Dr. Jones: That's exactly what I have been saying about this abdica-

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AAHS 2010 Research Grants

Annual Research Awards will be made by the Research Committee of the American Association for Hand Surgery. These awards were established to further the purpose of the Association as stated in its Bylaws and to foster creativity and innovation in basic and/or clinical research in all areas pertinent to hand surgery.

Awards and Eligibility

Up to three (3) grants in the amount up to \$5,000.00 USD each will be made for a one year period. Grants are available to residents, fellows, therapists and AAHS members. Up to three (3) investigators may be included on a single application. **One of the co-investigators must be an AAHS Active or Affiliate member.**

Application

The application consists of three (3) parts: 1) Investigator(s) demographic information; 2) Description of Research; and 3) Curriculum Vitae for each Investigator

The application must be obtained from: American Association for Hand Surgery, 444 East Algonquin Road, Arlington Heights, IL 60005 or www.handsurgery.org

The application must be received no later than November 1, 2009 in order for judging to be completed in time and the recipients to be announced at the Annual Meeting.

Guidelines

- The facility for research must coincide with the Principal Investigator's location for one (1) year following the receipt of the Award.
- The AAHS and Research Committee are required by the IRS to document disbursement of funds, as well as to maintain annual reports on the funded programs. Award recipients will be asked to provide financial and progress reports.
- The American Association for Hand Surgery must be acknowledged as the source of funding in any presentation or publication.
- It is expected that work supported by this grant be submitted for presentation at the Annual Meeting of AAHS within two (2) years of receipt of the Award.
- Yearly progress reports are requested. The final progress report should list publications which resulted from this initial seed funding.
- Funds must be returned to the American Association for Hand Surgery if the research is not undertaken within twelve (12) months of receipt of the Award.

Failure to follow these guidelines will disqualify the recipient from any further grant applications and from presenting any papers at the AAHS meetings for 3 years following such default.



Mail Grant Application to:

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efreeman@plasticsurgery.org

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tion of responsibility. Nobody wants to take responsibility at the federal level, at the state level, and at the hospital level. Nobody really gives a damn.

Dr. Levin: Right.

Dr. Jones: It's only our own personal responsibility that's supporting the system at this point in time. So it comes down to the lowest denominator or the lowest person on the totem pole—us. And if we say we're not taking call for a week, or when we all retire, then it is going to become a major, major crisis, especially when the wife of the CEO of

the hospital, or the wife of some senator has a major injury and cuts off her finger and can't find anybody to do anything about it.

Dr. Levin: All right. Well on that note I want to thank everybody. We've covered a lot of ground, and provided a lot of food for thought. **H**

HAND THERAPY PROFILE



Barbara Winthrop Rose, MA, OTR, CVE, CHT, FAOTA

Personal: I have the privilege to raise two wonderful children: Jenny, 22 years old, and Ted, 19 years old.

Education: 2004 Masters of Arts in Occupational Therapy, Texas Woman's University; 1979 Bachelors of Science in Occupational Therapy, University of Kansas

Employer: Co-Owner, Aaron & Rose Hand Therapy Services, Inc

AAHS Involvement: Member of AAHS

Best Part of My Job: Using my skills to help a patient transition from having a non-functional hand/UE to a functional hand and see them return to their life roles. Volunteer work in underserved populations, consulting with therapists and their hand-injured patients. I enjoy the challenge, camaraderie and sense of accomplishment as a "team member" of my professional associations whose goals are to provide support, continual

improvement, strength and unity to its members. It is rewarding to "give back" to a profession that has given me so much!

Major Accomplishments

(Professional): Co-founder and co-owner of the Houston Hand Rehabilitation Center, Inc. (1983-1994), the first outpatient, therapist-owned hand rehabilitation private practice in the greater Houston area. We combined our hand therapy skills with entrepreneurial skills as we grew and nurtured our practice to four locations, employing ~50 OTs, PTs and administrative staff.

Co-developer and coordinator of Clinical Education of Texas Woman's University Hand Therapy Fellowship (1996-2005), a specialty educational program for occupational and physical therapists that were motivated to specialize in the rehabilitation of the hand. My work involved co-writing and co-preparing the curriculum, teaching, coordination of all aspects of clinical education, and other areas of administration of the program. This was a graduate level educational fellowship. During the tenure of this program, over 80 OT's and PT's from 9 countries graduated and greater than 97% of those eligible to take the CHT exam, passed.

Co-developer of the clinical portion of Chevron's Rapid Response Upper Extremity Injury Prevention Program (2001-2002). With the initiation of this injury prevention program, Chevron experienced a reduction in their 40%-plus, upper extremity injury rate, secondary to

repetitive strain disorders to under 10%.

Initiated and organized numerous "grass roots" programs for the Texas Occupational Therapy Association and American Occupational Therapy Association to improve the visibility of occupational therapists in the Texas Legislature and Congress; expand our voice and provide greater access to those in need of our services (1987-1997). Highlights of those efforts are as follows:

- Chairperson of the first Committee for Legislative & Political Affairs, TOTA
- Spearheaded efforts to get sponsorship for Senate Bill 202 for inclusion of Occupational
- Therapy to be represented on the Health Care Advisory Committee to the newly formed Texas Worker's Compensation Commission, previously the Texas Industrial Accident Board.
- Texas Political Action Committee
- Chairperson, first Annual TOTA Legislative Day at the Texas State Capitol
- Chairperson, first AOTA National Legislative Conference, Washington DC

Clinical Specialties: Splinting and ergonomics.

Greatest Professional Challenge: Publishing my thesis—hopefully in 2009!

Three Words That Describe Me: Enthusiastic, creative, positive. **H**

Hand Trauma

Since the topic for this issue of Hand Surgery Quarterly deals with hand trauma, I thought we could briefly review some simple codes for hand fractures.

Finger fracture and dislocation codes are comprised of 19 items, all within the 26700 grouping. Eight of these codes deal with joint dislocation. MCP joint dislocation has its own code group; the PIP and DIP joints are bundled together as “interphalangeal joints.” Closed reduction of a joint without anesthesia has a specific code (26700 for MCP, 26770 for PIP/DIP). This would be used, for example, if the physician reduces a joint on the sideline or perhaps on initial assessment in an emergency room when a local anesthetic injection is not required. Reduction of the joint requiring anesthesia (local injection or IV sedation) warrants use of another code (26705 for MCP, 26775 for PIP/DIP). For dislocations that are very unstable and require percutaneous pinning, codes 26706 (MCP) and 26776 (PIP/DIP) are appropriate. If the dislocation is complex and an open surgical approach is required, then 26715 would be used for the MCP and 26785 would be used for the inter-

phalangeal joints. Remember that each of these codes corresponds to a single treated joint; extra codes would be warranted for each additional dislocated joint.

Treatment of phalangeal shaft fractures corresponds to another four codes. These designations address the proximal and middle phalangeal shafts; the distal phalanx has its own set of codes.

Distinction is made as to whether the fracture is treated closed without manipulation (26720), closed with manipulation or traction of some kind (26725), with percutaneous pinning (26727), or with an open surgical approach (26735).

Treatment codes for the distal phalanx are similar to those for the phalangeal shaft noted above. Closed treatment of a distal phalanx fracture without manipulation corresponds to 26750; manipulation of the fracture corresponds to 26755. Percutaneous fixation of the distal phalanx would warrant 26756 and an open approach to the fracture

Table 4: Articular Fractures of MCP, PIP, and DIP Joints

26740	Closed treatment without manipulation
26742	Closed treatment with manipulation
26746	Open surgical approach (with or without internal or external fixation)

corresponds to 26765.

The last three codes in the 26700 family deal with articular fractures. The MCP, PIP, and DIP joints are all included in this sub grouping.

Closed treatment of an articular fracture without manipulation corresponds to 26740; if manipulation is required, 26742 is appropriate. If an open surgical approach is needed to treat an articular fracture of any of the finger joints, then the correct code is 26746.

The various groupings for finger fracture and dislocation codes are noted in the tables below.

Remember that these codes apply to the thumb as well, and for each additional procedure performed, a-51 modifier is appropriate.

As one final note, while we on the topic of fractures, you should be aware that when coding for distal radius fractures, the use of an additional code for release of the brachioradialis tendon is not necessary. While it is doubtful that you would be reimbursed for adding such a code to the radius fracture procedure anyway, the radius fracture codes have been revised within the past few years and now account for different varieties of fracture patterns. Included in the work assessments for these codes was the additional dissection required to expose the more complex fracture patterns. Therefore, for the extra work you may perform when treating a complicated 2 or 3 part articular fracture, “it’s in there” when you use

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LEON S. BENSON, MD

Table 2: Proximal and Middle Phalangeal Shaft Fractures

26720	Closed treatment without manipulation
26725	Closed treatment with manipulation or traction (skin or skeletal)
26727	Percutaneous fixation
26735	Open surgical approach (with or without internal or external fixation)

Table 3: Distal Phalangeal Fractures

26750	Closed treatment without manipulation
26755	Closed treatment with manipulation or traction (skin or skeletal)
26756	Percutaneous fixation
26765	Open surgical approach (with or without internal or external fixation)

Table 1: Finger Dislocations

MCP Joint	
26700	Closed treatment without anesthesia
26705	Closed treatment with anesthesia
26706	Percutaneous fixation
26715	Open surgical approach
Interphalangeal Joints (PIP and DIP)	
26770	Closed treatment without anesthesia
26775	Closed treatment with anesthesia
26776	Percutaneous fixation
26785	Open surgical approach

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the single CPT code that corresponds to fixing the fracture. The subject of distal radius fracture

coding will be discussed in more detail when this topic is the main focus of a future issue of Hand Surgery Quarterly.

You Code It

A college football player sustains

a dorsal dislocation of the thumb MCP joint, a nondisplaced tuft fracture of the thumb distal phalanx, as well as a dorsal index PIP dislocation and a spiral shaft fracture of the long finger middle phalanx. The PIP dislocation of the index finger can be reduced closed (local anesthetic injected) but the thumb MCP joint is stuck and requires an open approach to disentangle the volar plate. The thumb distal phalanx tuft fracture requires only splint protection, but the long finger middle phalanx fracture is very unstable and requires an open reduction which is then stabilized with two screws.

Solution:

- 26715 Open approach to MCP dislocation (thumb in this case)
- 26750-51 Closed treatment of distal phalanx fracture without manipulation (thumb in this case)
- 26775-51 Closed treatment of interphalangeal dislocation (index PIP in this case) with anesthesia (local in this case)
- 26735-51 Open approach to phalangeal shaft fracture (long finger middle phalanx in this case) **H**



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AAHS Mentoring Program Volunteers

Below is a list of AAHS members who have generously offered to teach their expertise in specific areas, letting our members continue to learn the way we were

taught, as residents and fellows, in the clinic and operating room with a surgical mentor. For more information, please contact the AAHS Central Office. **H**

NAME	EMAIL	PROCEDURE(S)
R. D. Beckenbaugh, MD	beckenbaugh.robert@mayo.edu	Technique of pyrocarbon arthroplasty of the thumb carpometacarpal; and metacarpophalangeal and PIP joints of the digits
Richard Berger, MD, PhD	berger.richard@mayo.edu	Wrist surgery
Kyle Bickel, MD	kbickel@sflhand.com	Vascularized bone graft reconstruction for carpal pathology; complex fracture management in the hand and wrist; and arthroscopic wrist ganglion excision
Allen Bishop, MD	bishop.allen@mayo.edu	Brachial plexus reconstruction; carpal vascularized bone grafts; and microvascular free tissue transfers
James Chang, MD	changhand@aol.com	Dupuytren's Contracture; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy
Kevin Chung, MD	kechung@med.umich.edu	Rheumatoid and congenital
Tyson Cobb, MD	tycobb@mchsi.com	Endoscopic Cubital Tunnel Release
E. Gene Deune, MD	egdeune@jhmi.edu	Congenital hand anomalies; upper and lower extremity reconstruction for deficits due to trauma; cancer resection; and neurological disorders (i.e. brachial plexus)
Scott H. Kozin, MD	SKOZIN@shrinenet.org	Pediatrics
Don Lalonde, MD	drdonlalonde@nb.aibn.com	Wide awake approach to hand surgery
W. P. Andrew Lee, MD	leewp@upmc.edu	Post traumatic hand reconstruction; mini incision carpal tunnel release
Susan Mackinnon, MD	mackinnons@wustl.edu	Ulnar nerve surgery
Nash Naam, MD	drnaam@handdocs.com	SLAC wrist reconstruction; vascularized bone graft in treating scaphoid nonunions; ulnar shortening & radial shortening; PIP & MP joint arthroplasty; LRTI; arthroscopy of the CMC joint of the thumb
Daniel J. Nagle, MD	OOGIEN@aol.com	Wrist arthroscopy; endoscopic carpal tunnel release
Michael Neumeister, MD	mneumeister@siumed.edu	Basilar joint arthroplasty; peripheral nerve decompression
Jorge Orbay, MD	jlorbay@aol.com	Wrist fractures
A. Lee Osterman, MD	loster51@bellatlantic.net	Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.
Julian J. Pribaz, MD	jpribaz@partners.org	Soft tissue reconstruction; microsurgical reconstruction; spare parts surgery and extremity reconstruction
Michael Raab, MD	mikeraab1@earthlink.net	Corrective osteotomy (volar or dorsal) of distal radius malunion with iliac crest bone grafting
Jaiyoung Ryu	jryu@adelphia.net	Wrist reconstruction; distal radius fracture; and scaphoid fracture/nonunion
David Slutsky, MD	d-slutsky@msn.com	Use of volar wrist portals for wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; nonbridging external fixation of intra-articular distal radius fractures; nerve conduction studies for hand surgeons; and comparison of NCS and PSSD for the diagnosis of CTS
William Swartz, MD	william.swartz@verizon.net	Tendon transfer and ulnar nerve
Thomas Tung, MD	tungt@wustl.edu	Brachial plexus and nerve transfers
Joseph Upton, MD	jupton3@earthlink.net	Congenital hand surgery
Elvin Zook, MD	ezook@siumed.edu	Fingertip reconstruction